Maine Birth Defects Program

Confidential Medical Report

Please Print Clearly using Blue or Black Ink (See Instructions on Reverse Side)

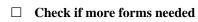
Today's Date:_____

Child's Information		
Name: Last	First M.I.	DOB:/ or
Sex: M F Undesignated	Birth Status: Live Still	EDD://
Birth Facility:	MR#	
Transfer Facility:	MR#	
Date of Discharge/Transfer:/	If Deceased: Date of Death:/	_/ Autopsy: Yes No
D'		
Diagnosis: □ Prenatal □ At Birth □ Other		
☐ Pending ☐ Confirmed Diagnosis confirmed by: ☐ Ultrasound ☐ Cytogenetics ☐ Physical Exam		
□ Encephalocele □ Coar □ Cleft Palate □ Doub □ Cleft Lip □ Hypo □ Cleft Lip/Palate □ Interr	roschisis halocele ctation of Aorta de Outlet Right Ventricle plastic Left Heart upted Aortic Arch onary Atresia with Intact Ventricular Septum	☐ Single Ventricle ☐ Tetralogy of Fallot ☐ Transposition of the Great Vessels ☐ Tricuspid Atresia ☐ Truncus Arteriosis ☐ Unknown/Suspected Cardiac
Mother's Information		
	DOB: /	/ MR#
Name: Last		
Address: Adoptive/Foster Parent(s) Name:		
Phone #:	Address: Phone #:	
Referrals Made: Children With Special Health Needs Program Date://_ Other: Date://_ Child Development Services Date://_ Date://_ Genetic Counseling Date://_ Date://_		
Provider Information:		
Primary Pediatric Provider:	Phone:	
Specialty Provider:	Phone:	
Reporting Source:	Phone:	

Telephone or fax completed form to:

Department of Health and Human Services Maine Birth Defects Program 11 SHS, 7th Floor, 286 Water Street Augusta, ME 04333-0011

Fax: (207) 287-5355



Yellow - Hospital/Provider copy



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